Maryland MRI, L.L.C
Registration Form

PATIENT DEMOGRAPHICS:

Last, First Name: _____ (MI): _____ Date of Birth: _____/ _____/ _____

Address: _____ Apt #: _____City: _____ State: _____ Zip code: _____

Home Phone#: (_____) _____ - _____Work Phone#: (_____) _____ - _____ ext: _____Cell Phone#: (_____) _____ - _____

Social Security #: _____ - ____ - _____ Sex: □ Male □ Female Marital Status: □Married □Single
Weight _____ □ Divorced □ Widowed

Employer's Name: _____

Address: _____Suite #_____City_____State_____Zip Code_____

ACCIDENT: Y / N AUTO □ WORKER'S COMP □ Date:____/____/_____ State: _____

ATTORNEY: Y / N Attorney's Name: _____

Company: _____ Phone#: (_____) _____ - _____ Fax #: (_____) _____ - _____

Address: _____City: _____ State: _____ Zip code: _____

QUESTIONS:

Are you Pregnant? □ YES Date of last menstrual period _____/_____/_____ □ NO □ N/A
Prior surgery in the area being scanned? □ YES* □ NO
* Please describe and give an approximate date of the surgery: _____

Name and Phone No. of person to call in the case of an emergency: _____

PRIMARY INSURANCE INFORMATION:

Are you the policyholder? Y / N If you circled N (no), please complete the policyholder's information below:

Last, First Name: _____ (MI): _____ Date of Birth: _____/ _____/ _____

Address: _____ Apt #: _____City: _____ State: _____ Zip code: _____

Home Phone#: (_____) _____ - _____ Work Phone#: (_____) _____ - _____ Ext: _____

Social Security #: _____ - ____ - _____ Sex: □ Male □ Female Relationship to patient: _____

Name and Address of Policyholder's Employer: _____

SECONDARY INSURANCE INFORMATION:

Are you the policyholder? Y / N If you circled N (no), please complete the policyholder's information below:

Last, First Name: _____ (MI): _____ Date of Birth: _____/ _____/ _____

Address: _____ Apt #: _____City: _____ State: _____ Zip code: _____

Home Phone#: (_____) _____ - _____ Work Phone#: (_____) _____ - _____ Ext: _____

Social Security #: _____ - ____ - _____ Sex: □ Male □ Female Relationship to patient: _____

Name and Address of Policyholder's Employer: _____

Name of Patient (Print) **Signature of Patient** **Date**

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PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION:

I authorize the release of my medical records to my physician. I authorize payment of benefits, as determined by both my primary and secondary insurance companies. I may still be responsible for any amount not paid by my insurance company. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim.

I attest that the information given is correct to the best of my knowledge. I have read and understand the contents of this form and I have had an opportunity to ask questions regarding the information on this form.

Name of Patient (Print) Signature of Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Maryland Open MRI reserves the right to modify the privacy practices outlined in the notice)

I have received a copy of the Notice of Privacy Practices for **Maryland MRI, LLC**

Name of Patient (Print) Signature of Patient Date

Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

Name of Representative (Print) Signature of Representative Date Relationship to Patient

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

☐ The patient was sedated and unable to sign

☐ The patient declined to sign the acknowledgement

☐ Other _____

Name of Patient (Print)

Name of Staff Member (Print) Date

Name of Witness (Print) Date